1997-98 SESSION COMMITTEE HEARING RECORDS

Committee Name:

Joint Committee on Finance (JC-Fi)

Sample:

Record of Comm. Proceedings … RCP
- 05hrAC-EdR_RCP_pt01a
- 05hrAC-EdR_RCP_pt01b
- 05hrAC-EdR_RCP_pt02

- *Appointments … Appt*
- **

- *Clearinghouse Rules … CRule*
- **

- *Committee Hearings … CH*
- **

- *Committee Reports … CR*
- **

- *Executive Sessions … ES*
- **

- *Hearing Records … HR*
- **

- *Miscellaneous … Misc*
- *97hrJC-Fi_Misc_pt65a_LFB*

- *Record of Comm. Proceedings … RCP*
- **

Health and Family Services

Medical Assistance

(LFB Budget Summary Document: Page 252)

LFB Summary Items for Which Issue Papers Have Been Prepared

Item #	Title
1	Overview of Medical Assistance Program (Paper #420)
2	Medical Assistance Base Reestimate (Paper #421)
3(part)	Selected Provider Rate Increases (Paper #422)
3(part)	Nursing Home Rate Increases (Paper #423)
5	Nursing Home Formula Adjustments (Paper #424)
6	Nursing Homes -- Delicensing Beds and the Minimum Occupancy Standard (Paper #425)
--	Intergovernmental Transfer Program (Paper #426)
--	Reestimate of GPR Revenues From MA Reimbursement for the State Centers (Paper #427)
8(part)	County Support for Certain Residents at the State Centers (Paper #428)
4	Emergency Medical Services (EMS) Rates (Paper #429)
11	Dental Sealants (Paper #430)
12	Case Management Services for Women Aged 45 through 64 (Paper #431)
17	Medical Assistance Copayments (Paper #432)
18	Validation of Hospital DRG Claims (Paper #433)
23	Medical Assistance Eligibility Unit (Paper #434)
--	Medical Assistance Administrative Costs Resulting from Federal Welfare Reform (Paper #435)
--	Federal Matching Rate for MEDS Contract (Paper #436)

To: Joint Committee on Finance

From: Bob Lang, Director
Legislative Fiscal Bureau

ISSUE

Overview of Medical Assistance Program Expenditures (DHFS -- Medical Assistance)

DISCUSSION POINTS

1. The medical assistance program is jointly financed with state and federal funds and administered by the state within federal guidelines pertaining to eligibility, types and range of services, payments levels for services and administrative operating procedures. Payments for services are made by the state to the individuals or entities that furnish the services.

The program supports the costs of providing acute and long-term care to persons who are aged, blind, disabled, children, members of families with dependent children and pregnant women who meet specified financial and nonfinancial criteria. Persons enrolled in the MA program are entitled to have payment made by the state for covered, medically necessary services furnished by certified providers.

2. The state receives matching payments from the federal government for expenditures made for covered services and administration. The rate of federal matching funds, or federal financial participation (FFP), is based upon a formula which compares a state's per capita income to national per capital income. The FFP rate is recalculated annually. The minimum federal share for any state is 50%. Wisconsin's per capita income has been increasing relative to the national per capital income over the past few years and, therefore, its FFP has been declining. In federal fiscal year (FFY) 1996-97, Wisconsin's FFP rate was 59.0%. For FFY 1997-98, Wisconsin's FFP is 58.84% and in FFY 1998-99 it is expected to be 58.55%.

3. Approximately $4.9 billion (all funds) is budgeted for MA program benefits in the 1995-97 biennium. Of this total, approximately $907.9 million in 1995-96 and $943.9 million in 1996-97 represents state GPR funding for the program. The GPR MA benefits appropriation is a biennial appropriation. Therefore, any surplus (deficit) which occurs in the first year of the

biennium is carried forward to the second year of the biennium. Any surplus (deficit) remaining in the appropriation at the end of the biennium is credited to the state's general fund.

4. A number of factors make it difficult to budget for the MA program. Fluctuations in the economy, the overall health of the population, and changes in medical technology and practice are not easily predicted and each of these factors could have a significant impact on overall program expenditures. In addition, over the course of the biennium, the Department implements administrative policies that affect program costs.

As recently as 1991-92, MA program expenditures exceeded the funding that was budgeted for the program in that year. However, over the past few years, actual program expenditures have been less than the budgeted amounts.

5. On April 24, 1997, this office prepared a memorandum for the Committee which, on a preliminary basis, identified a number of major GPR expenditure items of SB 77 that needed adjustment. The memorandum suggested that the medical assistance appropriation would lapse $17.7 million, in 1996-97, more than was anticipated in the construction of SB 77. Also, it was indicated that the amounts budgeted for MA in 1997-99 overstated projected expenditures by $12.6 million.

Since the April 24 memorandum, two things have occurred which will impact the MA appropriation for 1997-99. First, on May 5, 1997, the Joint Committee on Finance voted to expand eligibility for the healthy start program to cover children born after September 30, 1983, living in families with income up to 200% of the federal poverty level, effective January 1, 1998. The cost of this MA expansion is estimated to be $34.5 million GPR for the biennium. Second, this office has now completed a thorough review of amounts needed in the MA appropriation under SB 77 for 1997-99. Current reestimates of MA benefit expenditures are $31.1 million GPR less than the amounts in the bill.

The net effect of the healthy start expansion and the reestimate of 1997-99 MA benefit expenditures is to increase the MA benefits appropriation of SB 77 by $3.4 million GPR. The information is shown in the following table.

1997-99 MA Appropriation
($ in Millions)

	1997-98	1998-99	1997-99
SB 77	$905.3	$916.5	$1,821.8
Healthy Start Expansion	10.4	24.1	34.5
Reestimate	-15.1	-16.0	-31.1
Revised SB 77	$900.6	$924.6	$1,825.2
Revised vs. SB 77	-$4.7	$8.1	$3.4

The figures above reflect changes, to date, of the MA, GPR benefits appropriation for 1997-99. In addition, it is anticipated that the 1996-97 MA appropriation will lapse $18.7 million above the opening general fund balance amounts reflected in SB 77. This is the sum of $17.7 million from the April 24 memorandum, adjusted by an additional $1.0 million in the recent reestimate.

The papers that follow this overview address issues related to the medical assistance program, as contained within the Governor's 1997-99 budget recommendations.

Prepared by: Amie T. Goldman

To: Joint Committee on Finance

From: Bob Lang, Director
Legislative Fiscal Bureau

ISSUE

Medical Assistance Base Reestimate (DHFS -- Medical Assistance)

[LFB Summary: Page 255, #2]

CURRENT LAW

In 1996-97, the adjusted base funding level for medical assistance (MA) benefits is $943,855,900 GPR and $1,561,417,000 FED.

GOVERNOR

Decrease MA benefits funding by $70,418,600 ($38,594,300 GPR and $31,824,300 FED) in 1997-98 and $44,275,100 ($27,403,600 GPR and $16,871,500 FED) in 1998-99 to reflect reestimates of the projected cost for MA benefits funding in the 1997-99 biennium under current law. This base reestimate incorporates the following major adjustments:

a. *Reestimate of 1996-97 Base Year Costs:* Reduce base funding by $37,533,300 GPR and $50,415,700 FED in 1997-98 and $14,838,200 GPR and $14,140,600 FED in 1998-99 to reflect lower than projected spending for the 1996-97 base year than the budgeted amount.

b. *Decreased Federal Matching Rate:* Increase GPR funding and decrease FED funding by $7,895,400 in 1997-98 and by $3,960,100 in 1998-99 to reflect a projected decrease in the federal matching rate, from the current rate of 59.17% to 58.84% in 1997-98 and 58.54% in 1998-99.

c. *Higher IGT Payments:* Decrease GPR funding and increase FED funding by $15,676,000 in 1997-98 and by $8,169,400 in 1998-99 to reflect: (a) the effect of a recent

change in the claiming of federal matching funds under the intergovernmental transfer program for unreimbursed MA expenses of county-operated nursing homes; and (b) a reestimate of county losses available for use under the IGT program.

d. *Caseload Changes:* Decrease funding by $1,733,600 GPR and $2,035,600 FED in 1997-98 and by $12,145,600 GPR and $17,028,400 FED in 1998-99 to reflect projected changes in caseloads. Most of the decrease in caseload occurs in the AFDC-related group (families with dependent children).

e. *Intensity Changes:* Increase funding by $8,453,200 GPR and $12,846,400 FED in 1997-98 and $3,789,500 GPR and $10,088,200 FED in 1998-99 to meet higher projected average costs per MA-eligible resulting from such factors as greater use of MA services, use of new and more expensive services and a population shift to groups that heavily utilize MA services.

A summary of the Governor's caseload and service intensity assumptions are summarized in the following two tables.

SB 77
MA Caseload By Eligibility Category

					Percent Change From Previous Year		
	Actual	Projected					
Category	1995-96	1996-97	1997-98	1998-99	1996-97	1997-98	1998-99
Aged	50,846	49,659	48,470	47,195	-2.33%	-2.39%	-2.63%
Disabled	101,075	101,934	102,970	103,977	0.85	1.02	0.98
AFDC	253,068	223,955	201,708	177,198	-11.50	-9.93	-12.15
Other	66,786	76,875	85,476	94,669	15.11	11.19	10.76
Total Caseload	471,775	452,423	438,624	423,039	-4.10%	-3.05%	-3.55%

SB 77
MA Intensity, By Service Category

Service	Projected Annual Change 1997-98 and 1998-99
Dental	2.96%
Durable Medical Equipment/Supplies	3.53
Drugs	4.41
Family Planning	-9.27
Home Health Services	-3.05
Inpatient Hospital Services	2.94
Laboratory and X-Rays	2.44
Mental Health	19.99
Outpatient Hospital Services	0.21
Outpatient Hospital Services--Psychiatric	-10.60
Personal Care	2.35
Physicians	6.82
Therapies	-1.89
Transportation--Emergency	1.87
Transportation--Nonemergency	4.59
Other	2.66

DISCUSSION POINTS

1. In preparing its estimate of the costs to continue the MA program in the 1997-99 biennium, the administration reviewed 1995-96 actual spending for each MA service category and caseload data for each MA eligibility group. In addition, the administration identified historical changes in the average cost of services and used this information to prepare estimates of the cost to continue program changes implemented in the 1995-97 biennium.

2. This office used a similar methodology in developing cost estimates for the MA program in 1997-99. In addition to a reestimate of base funding for the program, this reestimate reflects adjustments related to projected caseload and service intensity for the 1997-99 biennium, based upon more recent information. The caseload projections were developed using information on actual caseloads through April, 1997, and a review of long-term trends in caseload growth. Intensity estimates were developed by reviewing changes in the average costs of services per eligible recipient during the past several years and information regarding programmatic changes during this time period.

3. The following table identifies current estimates of caseload and intensity changes for the 1997-99 biennium.

Reestimates of MA Caseload

Category	Actual 1995-96	Projected 1996-97	Projected 1997-98	Projected 1998-99	Percent Change From Previous Year 1996-97	Percent Change From Previous Year 1997-98	Percent Change From Previous Year 1998-99
Aged	50,846	49,373	48,139	47,176	-2.9%	-2.5%	-2.0%
Disabled	101,075	101,032	101,032	101,032	<0.1	0.0	0.0
AFDC	253,068	211,704	169,944	149,064	-16.3	-19.7*	-12.3*
Other	66,785	79,432	97,460	109,401	18.9	22.7*	12.3*
Total	471,775	441,541	416,575	406,673	-6.4%	-5.7%	-2.4%

*Note: Reflects a shift of individuals from the AFDC-related to the healthy start-related category. Therefore, the combined caseload reduction for these groups is projected to be -8.2% in 1997-98 and -3.3% in 1998-99.

Reestimates of MA Intensity

Service	Projected Annual Change 1997-98 and 1998-99
Dental	-1.50%
Durable Medical Equipment and Supplies	-1.00
Drugs	7.00
Family Planning	-2.76
Home Health Services	-1.00
Inpatient Hospital Services	0.00
Laboratory and X-Rays	0.00
Mental Health	5.00
Outpatient Hospital Services	1.33
Outpatient Hospital Services -- Psychiatric	-5.57
Personal Care	0.00
Physician and Clinic Services	1.18
Therapies	-2.00
Transportation -- Emergency	0.00
Transportation -- Nonemergency	5.36
Other	10.00

4. Based on current estimates of 1996-97 base funding and 1997-98 and 1998-99 caseload and intensity reestimates, funding provided in the bill should be decreased by a total of $15,056,500 GPR and increased by $19,889,400 FED in 1997-98 and decreased by $15,967,700 GPR and increased by $25,889,400 FED in 1998-99 from the amounts estimated by the Governor.

5. The major factor accounting for the change is that caseload declines accelerated in 1996-97 and were not fully reflected in the Governor's estimate. The current estimate for base

MA spending in 1996-97 is $16.9 million GPR less than estimated by the Governor. This difference is maintained in each year of the 1997-99 biennium.

6. The current estimate shows a decline in GPR costs for MA compared to the Governor, but shows an increase in federal costs. The reason for this disparity is that the Governor's estimate does not include the federal funds ($52 million in 1996-97) that match locally-supported CIP IB slots.

7. The Committee should be aware that the dramatic declines in AFDC-related caseload may, in part, be attributable to misunderstandings related to MA eligibility among recipients, county workers and providers as a result of federal welfare reform and the Wisconsin Works program. To the extent that this is true, and DHFS is able to re-educate and re-enroll recipients through outreach, the caseload decline may be moderated. At this time, it is difficult to predict the effects of increased DHFS outreach efforts on MA caseload.

8. Because of this concern, the current estimate assumes a slowing of the historical decline in the AFDC/other (primarily healthy start) groups. The total number of eligibles in the AFDC and other groups declined from 317,172 in April, 1996, to 281,561 in April, 1997, a decline of 35,611 individuals (11.7%). The current estimate projects that this combined group will decline from 281,561 in April, 1997, to 267,404 in January, 1998, a decline of 14,157 over nine months, which represents an annual decrease of 6.7%. From January, 1998, to the end of the 1997-99 biennium, the estimate assumes a 3.3% decline in this combined group.

MODIFICATION TO BILL

1. Adjust MA benefits funding by deleting $15,056,500 GPR and providing $19,889,400 FED in 1997-98 and deleting $15,967,700 GPR and providing $25,889,400 FED in 1998-99 to reflect reestimates of the cost to continue the current MA program in the 1997-99 biennium.

Modification	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	- $31,024,200	$45,778,800	$14,754,600

Prepared by: Richard Megna and Amie Goldman

MO# Modification

2	BURKE	Y	N A
	DECKER	Y	N A
	GEORGE	Y	N A
	JAUCH	Y	N A
	WINEKE	Y	N A
	SHIBILSKI	Y	N A
	COWLES	Y	N A
	PANZER	Y	N A
1	JENSEN	Y	N A
	OURADA	Y	N A
	HARSDORF	Y	N A
	ALBERS	Y	N A
	GARD	Y	N A
	KAUFERT	Y	N A
	LINTON	Y	N A
	COGGS	Y	N A

AYE 16 NO 0 ABS 0

To: Joint Committee on Finance

From: Bob Lang, Director
Legislative Fiscal Bureau

ISSUE

Selected Provider Rate Increases (DHFS -- Medical Assistance)

[LFB Summary: Page 256, #3(part)]

CURRENT LAW

Inpatient Hospital Services. Under the state's medical assistance (MA) program, inpatient hospital services are paid on a prospective payment system, commonly referred to as a diagnosis-related group (DRG) system. Under this system, each hospital determines the patient diagnosis and bills MA for the DRG related to a specific condition and/or treatment. Each DRG is assigned a weight which measure the relative resources required by a typical patient.

Hospitals are also reimbursed for allowable capital costs on a prospective basis. A hospital's capital payment is calculated by dividing the hospital's total capital costs, based on the most recent audited cost report, by the hospital's total costs, resulting in a ratio of capital costs to total costs. The total MA inpatient costs for the hospital are then multiplied by this ratio to yield an annualized MA-related capital costs figure. The amount is currently reduced by 15%. Certain rural hospitals are exempt from this capital reduction.

Non-Institutional Providers. Noninstitutional providers, including physicians, dentists and home health agencies, are paid the lessor of: (a) their usual and customary charges; or (b) maximum fees established by DHFS for each procedure. Changes in the maximum fee schedules are made by DHFS to implement modifications to rates authorized by the Legislature.

GOVERNOR

Provide $14,806,300 ($6,088,300 GPR and $8,718,000 FED) in 1997-98 and $26,426,600 ($10,936,700 GPR and $15,489,900 FED) in 1998-99 to increase MA rates paid to selected providers. The following table summarizes the percentage increase in rates compared to the rates under current law and state and federal funding which would be budgeted to support these increases.

TABLE 1

Governor's Recommended MA Rate Increases

	1997-98			1998-99		
Service Category	Rate Increase	Funding GPR	Funding FED	Rate Increase	Funding GPR	Funding FED
Inpatient Hospitals						
Acute Care						
Capital Payment		$904,600	$1,295,400		$910,500	$1,289,500
Rate Increase	2.1%	2,115,600	3,029,400	2.5%	4,717,500	6,681,500
IMD Hospitals						
Capital Payment		60,900	87,100		61,200	86,800
Pediatric Hospitals		822,400	1,177,600		827,700	1,172,300
Non-Institutional Providers	1.0	2,184,800	3,128,500	1.0	4,419,800	6,259,800
Total		**$6,088,300**	**$8,718,000**		**$10,936,700**	**$15,489,900**

DISCUSSION POINTS

Inpatient Hospitals

1. As Table 1 illustrates, the bill would increase rates for acute care inpatient hospital services by 2.1% in 1997-98 and an additional 2.5% in 1998-99. In addition, the bill would increase payment for allowable capital costs from 85% to 95% for all inpatient hospitals.

2. Federal law requires state MA programs to provide payment rates for hospitals and nursing facilities that are "reasonable and adequate" to meet the costs incurred by "efficiently and economically operated" facilities in providing care that meets federal and state quality and safety standards. This requirement of federal law is frequently referred to as the "EEO requirement" or the "Boren Amendment."

3. Federal law does not specify methods states must use to demonstrate compliance with the Boren Amendment. For this reason, DHFS cannot provide assurance that the rate of reimbursement for hospitals established in this budget will be sufficient to meet the federal EEO requirement. However, the administrations's proposal is intended to ensure that Wisconsin continues to comply the EEO requirement by providing increases in inpatient hospital rates to reflect the projected increase in the cost of inpatient hospital services.

4. The National Conference of State Legislatures, the National Governor's Association and others have long advocated for the repeal of the Boren Amendment. The recent federal balanced budget agreement between the President and Congressional leadership includes a provision which would repeal the Boren Amendment. While it is expected that the repeal of the Boren Amendment will be included in the 1997-98 federal budget, it is also possible that the amendment will be replaced with other provisions relating to the adequacy of hospital reimbursement.

5. The current estimate of the Governor's recommendation to increase hospital rates is $99,800 ($46,300 GPR and $53,500 FED) in 1997-98 and $220,600 ($90,400 GPR and $130,200 FED) more than the funding provided in the bill for this rate increase. Table 2 summarizes the estimated cost of providing alternative rate increases for inpatient hospital services.

TABLE 2

Alternative Hospital Rate Increases
(As Reestimated)

Rate Increase		Change to Bill			
		1997-98		1998-99	
1997-98	1998-99	GPR	FED	GPR	FED
0%	0%	-$2,115,600	-$3,029,400	-$4,717,500	-$6,681,500
1	1	-1,086,100	-1,561,400	-2,640,400	-3,738,700
2	2	-56,700	-93,300	-542,600	-766,600
2.1*	2.5*	46,300	53,500	90,400	130,200
3	3	972,800	1,374,700	1,575,900	2,234,845

*Governor's recommendation as reestimated.

Non-Institutional Providers

6. The Governor recommends a 1% increase in 1997-98 and an additional 1% increase in 1998-99 for all services provided by non-institutional providers. The following MA benefits and services would receive rate increases under the Governor's recommendation: (a) ambulance transportation; (b) certified nurse anesthetist; (c) chiropractic; (d) dental; (e) durable medical

equipment and disposable medical supplies; (f) drugs; (g) end stage renal disease; (h) family planning; (i) federally-qualified health clinics; (j) early and periodic screening diagnostic and testing (HealthCheck) services; (k) hearing aids; (l) home health; (m) hospice; (n) laboratory and x-ray; (o) outpatient hospital psychology and mental health; (p) personal care; (q) physicians and clinics; (r) podiatrist; (s) prenatal care coordination; (t) rural health clinic; (u) transportation by specialized medical vehicle; (v) therapies; and (w) vision.

7. The current estimate of the Governor's recommendation to increase rates for non-institutional services is $88,700 ($36,500 GPR and $52,200 FED) in 1997-98 and $178,500 ($73,000 GPR and $105,500 FED) in 1998-99 more than the funding providing in the bill for these rate increases. Table 3 summarizes the estimated cost of providing alternative rate increases for non-institutional services.

TABLE 3

Alternative Non-Institutional Provider Rate Increases
(As Reestimated)

Rate Increase		Change to Bill			
		1997-98		1998-99	
1997-98	1998-99	GPR	FED	GPR	FED
0%	0%	-$2,184,800	-$3,128,500	-$4,419,800	-$6,259,800
1%*	1%*	36,500	52,200	73,000	105,500
2%	2%	2,257,900	3,233,000	4,610,600	6,534,200
2.5%	2.5%	3,368,500	4,823,400	6,896,100	9,772,300
3%	3%	4,479,200	6,413,700	9,192,900	13,026,200

*Governor's recommendation as reestimated.

Pediatric Hospitals

8. In addition to the rate increase for acute care inpatient hospitals, the bill also provides $2 million (all funds) annually to fund a rate increase for pediatric hospital services. Hospitals that have more than 12,000 all-payer intensive care unit and general pediatric days per year would be eligible for a 12.9% increase to their base funding. Under this recommendation, it is estimated that $1,862,000 would be provided to Children's Hospital of Wisconsin and $138,000 would be provided to University Hospital of Wisconsin in each year. However, the bill contains no provisions relating to these supplemental hospital payments.

9. The administration provided a rate increase targeted primarily for Children's Hospital in order to address the unique position of Children's Hospital. Based on recent hospital cost reports submitted to DHFS, approximately 53% of Children's Hospital's patient days were

attributable to MA patients. This was the highest MA utilization rate reported to DHFS for that year. Approximately 50% of Children's Hospital's revenues are derived from the MA program.

Children's Hospital is the sole provider of certain pediatric procedures. For example, Children's Hospital is the only regional pediatric emergency/trauma center serving children with acute illness and severe injuries. Children's Hospital is also the only hospital in the state which performs pediatric bone marrow transplants. While Children's Hospital is located in Milwaukee County, it provides services to MA children who reside elsewhere in the state. According to information provided by the hospital, it serves 64% of MA-eligible children statewide who need inpatient hospital services. In southeast Wisconsin, 80% of MA-eligible children requiring hospitalization are served at Children's Hospital.

10. While Children's Hospital's MA utilization rate is the highest in the state, there are a number of hospitals in Milwaukee and other areas of the state which serve significant numbers of MA-eligible and low-income patients. DHFS collects hospital-specific information related to MA utilization rates for nearly all Wisconsin hospitals and calculates the percentage of patient days attributable to MA recipients. This information is used by the Department to calculate disproportionate share payments under the MA program. Disproportionate share payments are adjustments made to a hospital's DRG base rate and other hospital expenses, if the hospital provides a disproportionate share of services to MA-eligible and low-income patients.

In 1996-97, hospitals with an MA utilization rate above 19.3% qualified for a disproportionate share payment under the MA program. Including Children's Hospital, 19 in-state and six out-of-state hospitals qualified for this payment. University Hospital of Wisconsin, which would also benefit from the Governor's recommended pediatric hospital rate increase, had an MA utilization rate of approximately 11%.

11. Since the disproportionate share payment adjustment for any hospital is based on that hospital's MA utilization rate, it could be argued that this system currently provides compensation to Children's Hospital to address the magnitude of its MA utilization rate. In other words, because Children's Hospital's MA utilization rate is higher than any hospital in the state, its disproportionate share payment adjustment is higher than any hospital in the state.

12. While most Wisconsin hospitals, including Children's Hospital, are non-profit facilities, hospital revenue and gains can and do exceed expenses and losses at many facilities. The Office of Health Care Information (OHCI) collects financial information on most Wisconsin hospitals. Table 4 summarizes MA utilization rates, disproportionate share adjustments, profit margins and net income for each of the 19 in-state disproportionate share hospitals. Net income is defined as the excess (or deficit) of revenue and gains minus expenses and losses. The profit margin data represents the hospital's net income as a percent of total revenue and nonoperating gains (losses). Data from the most recent OHCI Wisconsin hospital guide and data collected by DHFS were used to compile the following table.

TABLE 4

1996-97 Disproportionate Share Hospitals

Hospital	City	MA Utilization Rate	Disproportionate Share Adjustment	1995 Profit Margin	1995 Net Income
Statewide Average		**10.84%**		**4.80%**	
Children's Hospital of Wisconsin	Milwaukee	53.30	5.50	8.20	$13,023,268
Sinai Samaritan	Milwaukee	44.58	4.86	1.80	3,390,331
Libertas	Green Bay	43.24	4.76	11.50	160,844
Northwest General	Milwaukee	32.20	3.95	2.80	350,607
Charter	West Allis	29.46	3.75	19.30	1,972,755
Milwaukee County Mental Health	Milwaukee	29.03	3.72	0.00	0
Brown County Mental Health	Green Bay	26.88	3.56	0.00	0
Froedtert Hospital	Milwaukee	26.87*	3.56	5.30	8,428,000
St. Luke's	Racine	25.26	3.44	-9.30	-4,124,657
Sacred Heart	Tomahawk	24.54	3.39	9.00**	3,455,262**
St. Mary's Hill	Milwaukee	23.43	3.30	-14.50	-726,791
Stoughton	Stoughton	22.77	3.26	1.70	193,478
Bellin Psychiatric	Green Bay	22.74	3.25	12.50	1,116,248
Mendota	Madison	22.40	3.23	-5.40	-1,755,066
Winnebago	Winnebago	21.15	3.14	-5.50	-1,596,637
Memorial Medical Center	Ashland	20.10	3.06	6.20	1,583,716
St. Josephs	Chippewa Falls	19.58	3.02	3.70	989,664
Luther	Eau Claire	19.44	3.01	6.00	4,455,956
St. Joseph's	Milwaukee	19.44	3.01	5.90	10,047,386

* Combined with data from John Doyne Hospital
**Combined with data from Saint Mary's Hospital, Rhinelander.

Source: OHCI 1995 Hospital Guide and DHFS.

As this table illustrates, Children's Hospital receives an additional 5.5% on all of its payments under the MA program as a disproportionate share adjustment. This table also illustrates that Children's Hospital's profit margin is approximately 70% higher than the average profit margin for all hospitals.

In 1996-97, $4.7 million in disproportionate share payments was paid to the 25 in- and out-of-state disproportionate share hospitals. Of this total, $1,118,000 was paid to Children's Hospital.

For these reasons, the Committee could deny the Governor's recommendation to provide a pediatric hospital rate increase targeted for Children's Hospital and University Hospital of Wisconsin.

13. Another argument for providing a pediatric hospital rate increase could be that the current reimbursement system does not adequately reimburse hospitals for pediatric inpatient services. Children's Hospital has asserted that MA reimbursement does not cover a sufficient proportion of the hospital's costs for services provided to MA recipients. Therefore, as an alternative to the Governor's proposal, the Committee may want to provide $2.0 million annually to increase rates for pediatric inpatient services, but delete the Governor's recommendation to target this increase to hospitals with more than 12,000 all-payer intensive care unit and general pediatric days. If the Committee chose this alternative, all hospitals, including Children's Hospital and University Hospital of Wisconsin, which provide pediatric inpatient hospitals services to MA recipients would benefit from the rate increase.

ALTERNATIVES TO BILL

1. Inpatient Hospitals

1a. Approve the Governor's recommendation to increase rates for acute care inpatient hospital services by 2.1% in 1997-98 and 2.5% in 1998-99. In addition, increase payment for allowable capital costs from 85% to 95%. Finally, increase MA benefits funding by $99,800 ($46,300 GPR and $53,500 FED) in 1997-98 and $220,600 ($90,400 GPR and $130,200 FED) in 1998-99 to reflect the current estimated cost of this rate increase.

Alternative 1a	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	$384,400	$605,400	$989,800

1b. Modify the Governor's recommendation, relating to rate increases for inpatient hospital services, based on one of the options in the following table.

Alternative Hospital Rate Increases
(As Reestimated)

Rate Increase		Change to Bill			
		1997-98		1998-99	
1997-98	1998-99	GPR	FED	GPR	FED
0%	0%	-$2,115,600	-$3,029,400	-$4,717,500	-$6,681,500
1	1	-1,086,100	-1,561,400	-2,640,400	-3,738,700
2	2	-56,700	-93,300	-542,600	-766,600
2.1*	2.5*	46,300	53,500	90,400	130,200
3	3	972,800	1,374,700	1,575,900	2,234,800

*Governor's recommendation as reestimated.

2. Non-institutional Providers

2a. Approve the Governor's recommendation to provide a 1% increase in 1997-98 and an additional 1% increase in 1998-99 for all services provided by non-institutional providers. In addition, increase MA benefits funding by $88,700 ($36,500 GPR and $52,200 FED) in 1997-98 and $178,500 ($73,000 GPR and $105,500 FED) in 1998-99 to reflect the current estimated cost of this rate increase.

Alternative 2a	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	$109,500	$157,700	$267,200

2b. Modify the Governor's recommendation, relating to rate increases for non-institutional services, based on one of the options in the following table.

Alternative Non-Institutional Provider Rate Increases
(As Reestimated)

Rate Increase		Change to Bill			
		1997-98		1998-99	
1997-98	1998-99	GPR	FED	GPR	FED
0%	0%	-$2,184,800	-$3,128,500	-$4,419,800	-$6,259,800
1%*	1%*	36,500	52,200	73,000	105,500
2%	2%	2,257,900	3,233,000	4,610,600	6,534,200
2.5%	2.5%	3,368,500	4,823,400	6,896,100	9,772,300
3%	3%	4,479,200	6,413,700	9,192,900	13,026,200

*Governor's recommendation as reestimated.

3. Pediatric Hospitals

3a. Approve the Governor's recommendation to provide $2,000,000 annually to fund a 12.9% rate increase for hospitals that have more than 12,000 all-payer intensive care unit and general pediatric days per year.

3b. Modify the Governor's recommendation by deleting the requirement that the rate increase be provided to hospitals with more than 12,000 all-payer intensive care and general pediatric days per year. In addition, direct DHFS increase inpatient hospital reimbursement for pediatric services by $2,000,000 annually.

3c. Maintain current law.

Alternative 3c	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	- $1,650,100	- $2,349,900	- $4,000,000

Prepared by: Amie T. Goldman

MO#_____

BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A
JENSEN	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A

AYE _____ NO _____ ABS _____

To: Joint Committee on Finance

From: Bob Lang, Director
Legislative Fiscal Bureau

Revision to LFB Paper #422 -- Selected Provider Rate Increases (DHFS -- Medical Assistance)

[LFB Summary: Page 256, #3(part)]

Subsequent to the preparation of LFB paper #422, it was discovered the Governor's recommended 1% rate increase for non-institutional providers included services which are currently reimbursed under a cost-based formula. Reimbursement for federally qualified health centers (FQHCs), rural health clinics and end-stage renal disease services are reimbursed based on their costs and, therefore, should not have been included in the provider rate increase estimate.

In addition, a technical correction is required related to the rate increase provided for drugs. MA reimbursement for drugs is cost-based. Pharmacists and physicians are reimbursed the lesser of: (a) the usual and customary charge; or (b) the amount that would result using a variety of formulas, including the estimated acquisition cost minus 10%. Reimbursement for over-the-counter drugs is limited to the amount paid for non-prescription generic drugs. In addition, pharmacists and physicians are paid a dispensing fee for each prescription. Therefore, the 1% increase should apply to the dispensing fee, rather than to the total reimbursement for the prescription, as assumed in SB 77.

SB 77 provides $2,184,800 GPR and $3,128,500 FED in 1997-98 and $4,419,800 GPR and $6,259,800 FED in 1998-99 to support a 1% rate increase for non-institutional providers. The current estimated cost of a 1% rate increase for non-institutional providers is $1,388,500 GPR and $1,988,300 FED in 1997-98 and $2,808,400 GPR and $3,978,900 FED in 1998-99.

In addition, the box in Alternative 1a of that paper needs to be modified to accurately reflect the funding in the text.

The alternatives to LFB paper #422, as corrected, are as follows:

ALTERNATIVES TO BILL

1. Inpatient Hospitals

Revised 1a. Approve the Governor's recommendation to increase rates for acute care inpatient hospital services by 2.1% in 1997-98 and 2.5% in 1998-99. In addition, increase payment for allowable capital costs from 85% to 95%. Finally, increase MA benefits funding by $99,800 ($46,300 GPR and $53,500 FED) in 1997-98 and $220,600 ($90,400 GPR and $130,200 FED) in 1998-99 to reflect the current estimated cost of this rate increase.

Alternative 1a	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	$136,700	$183,700	$320,400

1b. Modify the Governor's recommendation, relating to rate increases for inpatient hospital services, based on one of the options in the following table.

Alternative Hospital Rate Increases
(As Reestimated)

Rate Increase		Change to Bill			
		1997-98		1998-99	
1997-98	1998-99	GPR	FED	GPR	FED
0%	0%	-$2,115,600	-$3,029,400	-$4,717,500	-$6,681,500
1	1	-1,086,100	-1,561,400	-2,640,400	-3,738,700
2	2	-56,700	-93,300	-542,600	-766,600
2.1*	2.5*	46,300	53,500	90,400	130,200
3	3	972,800	1,374,700	1,575,900	2,234,800

*Governor's recommendation as reestimated.

2. Non-institutional Providers

Revised 2a. Move the Governor's recommendation to provide a 1% increase in 1997-98 and an additional 1% increase in 1998-99 for all services provided by non-institutional providers. In addition, decrease MA benefits funding by $1,936,500 ($796,300 GPR and $1,140,200 FED)

in 1997-98 and $3,892,300 ($1,611,400 GPR and $2,280,900 FED) in 1998-99 to reflect the current estimated cost of this rate increase.

Alternative 2a	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	- $2,407,700	- $3,421,100	- $5,828,800

Revised 2b. Modify the Governor's recommendation, relating to rate increases for non-institutional services, based on one of the options in the following table.

Alternative Non-Institutional Provider Rate Increases
(As Reestimated)

Rate Increase		Change to Bill			
		1997-98		1998-99	
1997-98	1998-99	GPR	FED	GPR	FED
0%	0%	-$2,184,800	-$3,128,500	-$4,419,800	-$6,259,800
1*	1*	-796,300	-1,140,200	-1,611,400	-2,280,900
2	2	592,300	847,900	1,225,000	1,737,500
2.5	2.5	1,286,500	1,842,100	2,653,600	3,761,700
3	3	1,980,800	2,836,200	4,089,300	5,795,600

*Governor's Recommendation as Reestimated

3. Pediatric Hospitals

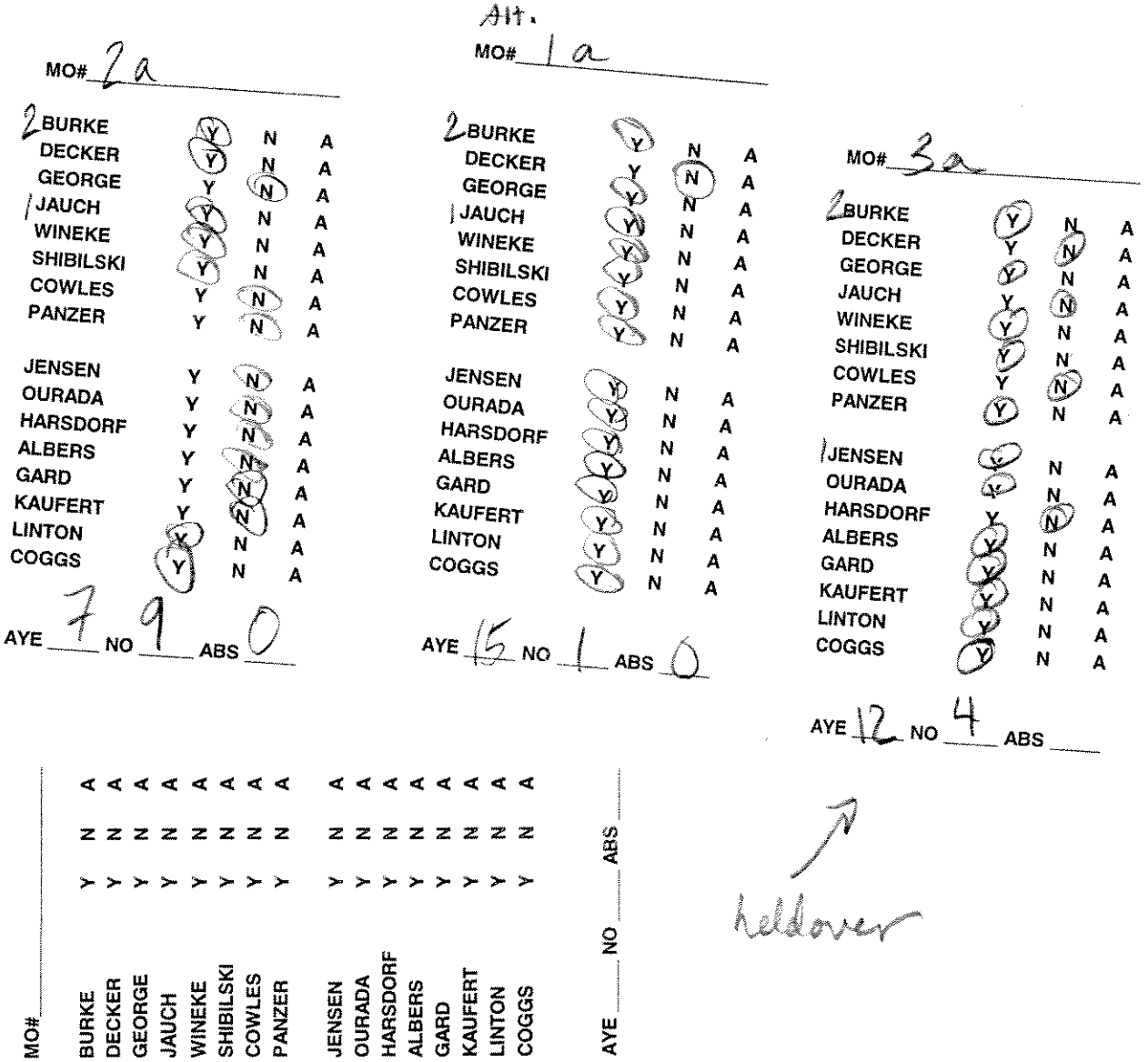
3a. Approve the Governor's recommendation to provide $2,000,000 annually to fund a 12.9% rate increase for hospitals that have more than 12,000 all-payer intensive care unit and general pediatric days per year.

3b. Modify the Governor's recommendation by deleting the requirement that the rate increase be provided to hospitals with more than 12,000 all-payer intensive care and general pediatric days per year. In addition, direct DHFS increase inpatient hospital reimbursement for pediatric services by $2,000,000 annually.

3c. Maintain current law.

Alternative 3c	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	- $1,650,100	- $2,349,900	- $4,000,000

Prepared by: Amie T. Goldman



Representative Jensen

HEALTH AND FAMILY SERVICES

Non-Institutional Provider Rate Increases

Motion:

Provide $722,000 GPR and $1,033,700 FED in 1997-98 and $1,490,000 GPR and $2,113,000 FED in 1998-99 to support the costs of a 2% rate increase in 1997-98 and an additional 2% rate increase in 1998-99 for all services provided by non-institutional providers except dentists, and a 5% rate increase in each year for services provided by dentists.

Note:

Senate Bill 77 would provide a 1% increase in each year of the biennium for all services provided by non-institutional providers.

This motion would instead provide a 2% annual rate increase for noninstitutional providers except dentists, and a 5% annual rate increase for services provided by dentists.

[Change to Bill: $2,212,000 GPR and $3,146,600 FED]

MO# 1115

BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A
JENSEN	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A

AYE 16 NO 0 ABS 0

To: Joint Committee on Finance

From: Bob Lang, Director
Legislative Fiscal Bureau

ISSUE

Nursing Home Rate Increases (DHFS -- Medical Assistance)

[LFB Summary: Page 256, #3 (part)]

CURRENT LAW

The Department of Health and Family Services (DHFS) reimburses nursing homes for care provided to medical assistance (MA) recipients through payments based on a daily rate adjusted for patient levels of care. The daily rate is determined annually by DHFS based on the amount of funding budgeted for MA nursing home reimbursement.

State law requires DHFS to make payments under six cost categories ("cost centers"), which include: (a) direct care; (b) support services; (c) administrative and general; (d) fuel and other utilities; (e) property taxes, municipal services or assessments; and (f) capital.

Under federal law, the MA program must reimburse nursing homes for costs incurred by efficiently and economically operated facilities. This requirement of federal law is often referred to as the "Boren Amendment" or "EEO requirement." In addition, payments to nursing homes may not exceed the amount that would be paid under medicare payment principles. Thus, federal MA payments to nursing homes are limited by the "medicare upper limit."

GOVERNOR

Provide $50,975,000 ($20,960,900 GPR and $30,014,100 FED) in 1997-98 and $81,297,500 ($33,645,000 GPR and $47,652,500 FED) in 1998-99 to increase MA payments to nursing homes.

Provide that aggregate payments to nursing homes, exclusive of increases due to higher recipient utilization of nursing home care and other specified items, would increase over the prior year payments by the lesser of 6.1% or $50,975,000 in 1997-98 and by the lesser of 3.5% or $30,322,500 in 1998-99. Because of the design of the nursing home reimbursement formula, which reimburses a nursing home's allowable costs up to established maximum rates based on median nursing home costs in the state, a nursing home may receive rate increases that are either higher or lower than the 6.1% and 3.5% for the respective years.

DISCUSSION POINTS

Effect of Rate Increases and Formula Changes

1. The aggregate rate increases of $50,975,000 (or 6.1% rate, if lower) in 1997-98 and an additional $30,322,500 (or 3.5% rate, if lower) in 1998-99 reflect the net increase with the formula changes recommended by the Governor. Consequently, the recommended formula changes would not reduce these recommended rate increases.

2. Questions have been raised as to whether the recommended funding increase or the recommended formula parameters would dominate if, once the actual data is utilized, the two were found to be inconsistent. Since the recommended funding level is based on the formula parameters applied to a prior year data set, the formula parameters recommended by the Governor may generate a lower level of funding than is provided in SB 77 when applied to the actual cost data. In this case, the recommended funding levels would control and the formula parameters would be adjusted to expend the full $51.0 million (or increase rates 6.1%) in 1997-98 and $30.3 million (or increase rates 3.5%) in 1998-99 budgeted to increase nursing home reimbursement. Although minimum limits for the cost center targets are specified in statute, the statutes do not specify the exact value of these formula parameters and, consequently, DHFS has the authority to adjust these formula parameters.

3. Under the MA nursing home formula, each home receives a payment rate that is relative to the actual costs of that home to the extent that those costs are within the cost center maximums in the formula. Because the maximums are related to statewide median costs for those items, not every home receives all of its costs. Also, because some homes are below the maximum and some are above, each home may receive a percentage rate increase that is much different that the average increase. Thus, even if the rate increase equals 6.1% in 1997-98 on average, an individual home may experience a much different rate increase. Although the Governor recommended a number of formula changes, the change with the largest impact is the reduction of the direct care target from 110% to 102%. This change will cause homes with higher than average direct care costs to experience proportionately lower rate increases than the average. Also, homes with a higher than average number of medicare patients will experience a lower than average increase.

EEO Requirement

4. A critical factor in establishing the reimbursement formula for nursing homes is the EEO requirement. Federal law does not specify methods the state must use to demonstrate compliance with the EEO requirement. States must develop their own methods for assuring that the rate of reimbursement established for nursing homes will be sufficient to meet the EEO requirement. To the extent the rate increase or other changes to the nursing home formula are not sufficient to meet EEO requirement, reimbursement for nursing homes may be challenged through legal action.

5. The method used by DHFS to ensure compliance with the EEO requirement is to establish the cost center targets at levels sufficient to reimburse all allowable projected costs for at least 50% of the nursing homes in each cost center. This test would require that, in general, the cost center targets would have to be at least 100% of the statewide median cost for each cost center. Since the Department must project costs (actual costs for the reimbursement period are not known when rates are set) for the rate period, setting the targets at 100% of the projected median cost may subject the state to some risk, if inflation is higher than anticipated. Setting the targets at 100% does not leave any margin for error.

6. The Governor's recommendation sets the targets for the cost centers at 102% of the statewide median. Since there is some uncertainty as to the level of costs in the reimbursement period, the Governor's recommendation could be viewed as close to the minimum amount of funding needed to meet the EEO requirement, given that some margin for error must be incorporated.

7. Although the Governor's recommended parameter values could be characterized as the minimum level for meeting the EEO requirement, it may be that the associated funding level is more than the amount required to fund rates under those parameter values. DHFS staff ran a simulation of the nursing home formula using the Governor's recommended parameter values on more recent cost information than was available when the budget was developed. This recent simulation suggests that the funding provided for nursing home rate increases could be reduced by $8,266,500 (all funds) in 1997-98 and by $8,555,800 (all funds) in 1998-99 while still meeting the state's test for complying with the EEO requirement.

8. Although the recent simulation is based on more up-to-date information, it is not based on the complete data set that will be used for setting 1997-98 rates. Not every home has submitted its 1995 cost report, which is the report that will be the basis for the 1997-98 rate calculation. Also, estimates of Wisconsin inflation, based on comparing unaudited 1996 and 1995 cost reports are not available at this time. However, the recent simulation is based on approximately 85% of all nursing homes, and DHFS utilized the highest adjustment for past estimates of Wisconsin inflation.

Historical Rate Increases

9. The recent federal budget agreement reached between the President and Congressional leaders includes, as a flexibility option, the repeal of the EEO requirement as one component of approximately $16 billion in gross MA savings that must be realized over the next five years. However, this agreement is still in the early stages of the legislative process.

10. Tables 1 and 2 provide historical information on the level of reimbursement rates to nursing homes over the last several years. Table 1 reflects information from the annual survey of nursing homes for which 1995 is the last available year. Table 1 lists: (a) the average MA reimbursement rate for each of the different levels of care; (b) the average reimbursement rate for medicare and the private pay rate for the SNF level of care; and (c) the average total cost per day. It is difficult to compare these average cost figures to the changes in MA rates, since the rates are based on level of care, while the costs reflect a combination of all levels of care and groups.

TABLE 1

Average Reimbursement Rates
Annual Survey of Nursing Homes
1992-1995

	1992	1993	1994	1995	Annual Rate Of Increase 1992 to 1995
Medical Assistance					
Intensive Skilled Nursing (ISN)	$90.54	$93.18	$96.90	$100.70	3.6%
Skilled Nursing (SNF)	75.92	78.65	82.24	85.67	4.1
Intermediate Care (ICF-1)	63.28	66.14	69.18	72.55	4.7
Limited Care (ICF-2)	62.97	66.57	69.75	74.42	5.7
Personal Care (ICF-3)	47.10	51.77	50.12	61.13	9.1
Residential Care (ICF-4)	37.37	47.72	40.80	47.83	8.6
Developmental Disabilities (All)	94.94	101.99	106.89	116.92	7.2
Average MA (All Levels)	$75.19	$78.40	$84.77	$88.54	5.6%
Medicare SNF*	$132.56	$163.43	$174.39	$192.44	13.2%
Private Pay SNF	$94.76	$100.71	$106.32	$112.6	5.9%
Average Costs per Patient Day	$94.88	$99.48	$104.35	$108.21	4.5%

*The medicare rate includes costs for therapies, physician services and other costs that are separately bill for under MA.

11. Table 1 indicates that for the SNF level of care, which is the largest group, the average annual growth rate in the MA reimbursement rate was 4.1 % over the 1992 to 1995 period. For all levels of the care, the MA reimbursement rate increased at an average annual rate of 5.6%. By comparison, the private rate for SNF care increased 5.9% annually and the medicare rate by 13.2% annually. Average total patient costs over this period increased at an annual rate of 4.5%.

TABLE 2

Average MA Reimbursement Rates After Patient Share 1992-93 to 1996-97

	FY 93	FY 94	FY 95	FY 96	FY 97	Increase FY 95 to FY 96	Increase FY 96 to FY 97	Annual Rate of Increase FY 93 to FY 97
Skilled Nursing (SNF)	$61.61	$65.04	$68.29	$70.05	$72.31	2.6%	3.2%	4.1%
Intermediate Care (ICF-1 & 2)	47.78	50.99	53.13	54.46	56.23	2.5	3.3	4.2
Personal Care (ICF-3)	33.16	37.98	38.39	39.00	38.00	1.6	-2.6	3.5
Residential Care (ICF-4)	24.30	20.34	17.76	16.05	11.24	-9.6	-30.0	-17.5
Developmental Disabilities (ALL)	89.49	94.67	103.74	106.30	111.72	2.5	5.1	5.7
All Levels	$60.49	$64.11	$67.77	$69.68	$72.23	2.8%	3.7%	4.5%

Source: DHFS MA 543 Reports

12. Since the annual survey provides information only through 1995, Table 2 is included to provide an indication of the changes in reimbursement rates in the last two years. Table 2 shows the average reimbursement rate paid by MA by level of care. These reimbursement rates are net of patient share and thus, are less than the rates indicates in Table 1. The data in Table 2 does not provide as good of an indication of the change in reimbursement rates, since the changes may be influenced by changes in relative amounts of cost sharing from the MA recipients. Table 2 indicates that the MA reimbursement rate increases have increased at a lower rate over the last two years than in previous years. Table 2 shows that for all levels of care, the MA rate increased at 2.8% in 1995-96 and 3.66% in 1996-97.

Comparisons with Other Services

13. Rate increases for nursing homes have been larger than for other types of MA providers. Inpatient hospitals, which are also subject to the EEO requirement, received rate increases that averaged 2.75% in 1993-94 and 3.25% in 1994-95 and 3% annually in the 1995-97 biennium. The Governor recommends rate increases of 2.1% in 1997-98 and 2.5% in 1998-99 for inpatient hospitals for the 1997-99 biennium. Other than hospitals and nursing homes, there

have been limited rate increases for MA providers over the 1993-97 period. Selected non-institutional providers received a 1% rate increase in 1994-95 and the Governor recommends a rate increase of 1% per year for noninstitutional providers in the 1997-99 biennium.

14. Advocates of home- and community-based long-term care have argued that there is an institutional bias in funding MA-supported services. Nursing home care is an entitlement, while funding for the MA waiver programs, such as the community options waiver (COP-W) and the community integration program (CIP IB), are limited and subject to waiting lists for services.

15. The Governor's recommendations for community-based long-term care programs for 1997-99 are as follows: (a) provide $272,000 GPR and $389,500 FED in 1997-98 and $821,300 GPR and $1,163,200 FED in 1998-99 to increase the number of CIP IB placements by 75 in 1997-98 and by another 75 in 1998-99. (b) provide $1,067,600 GPR and $752,000 FED in 1997-98 and $3,143,100 GPR and $2,276,900 FED in 1998-99 for the COP program; and (c) increase the maximum rate paid to counties for the costs of a CIP IA placement made after July 1, 1997, to $184 per day, from the current level of $153 per day. DHFS is also pursuing a long-term care initiative that has as one of its goals the elimination of any bias for a particular type of long-term care and that funding would follow the recipient. DHFS plans to introduce legislation for the long-term care initiative in the Fall of 1997.

ALTERNATIVES TO BILL

1. Approve the Governor's recommendations to provide $50,975,000 ($20,960,900 GPR and $30,014,100 FED) in 1997-98 and $81,297,500 ($33,645,000 GPR and $47,652,500 FED) in 1998-99 to increase MA payments to nursing homes.

2. Reduce funding in SB 77 by $3,399,200 GPR and $4,867,300 FED in 1997-98 and $3,540,200 GPR and $5,015,600 FED in 1998-99 to reflect more recent projections of the funding required to meet the EEO requirement.

Alternative 2	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	- $6,939,400	- $9,882,900	- $16,822,300

3. Adopt the funding modification contained in Alternative (2). In addition, specify that DHFS would not expend all of the funds provided for nursing home rate increases if the recommended cost center targets and other formula parameters could be funded at a lower cost, based on more complete data at the time DHFS sets the nursing home rates.

Representative Jensen

HEALTH AND FAMILY SERVICES

Funding for Additional COP-Waiver Placements

Motion:

Move to provide $1,726,000 GPR and $2,088,000 FED in 1998-99 to fund 800 additional placements that would be made under the community options medical assistance waiver (COP-W) program, beginning January 1, 1999.

Note:

SB 77 provides funding to support: (a) 400 additional placements in 1997-98 (120 regular COP and 280 COP-W placements), beginning January 1, 1998; and (b) an additional 400 placements in 1998-99 (120 regular COP and 280 COP-W placements), beginning January 1, 1999. In total, 800 additional slots would be provided by the end of the 1997-99 biennium.

This motion would provide an additional 800 COP-W placements, beginning on January 1, 1999. Together with the Governor's recommendation, this would provide a total of 1,600 additional placements by the end of the 1997-99 biennium.

[Change to Bill: $1,726,000 GPR and $2,088,000 FED]

MO#_____

BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A
JENSEN	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A

AYE 9 NO 8 ABS 0

Motion #1116

Representative Ourada

HEALTH AND FAMILY SERVICES

Direct Care Target for Nursing Home Reimbursement

Motion:

Move to modify Alternative 2 in LFB Paper #423 to add the provision that any part of the aggregate funding increase budgeted in 1997-98 for nursing home rate increases that is in excess of the amount needed to support the formula values recommended by the Governor be used solely to increase the direct care target above 102% of the statewide median.

Note:

Based on a recent simulation conducted by the Department, it is estimated that the recommended funding level for 1997-98 is $8,266,500 higher than would be needed to fund the Governor's recommended formula values and comply with the federal EEO requirement. However, when all actual cost data is received, it may be the case that the net funding provided after the reductions under Alternative 2 may be more than needed to fund the Governor's formula values. This motion would direct that any excess funding be directed to increase the target for direct care.

MO# 2050

BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A
JENSEN	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A

Motion #2050

AYE 16 NO 0 ABS 0

Alternative 3	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	- $6,939,400	- $9,882,900	- $16,822,300

Prepared by: Richard Megna

MO#_____

BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A
JENSEN	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A

AYE _____ NO _____ ABS _____

To: Joint Committee on Finance

From: Bob Lang, Director
Legislative Fiscal Bureau

ISSUE

Nursing Home Formula Adjustments (DHFS -- Medical Assistance)

[LFB Summary: Page 259, #5]

CURRENT LAW

The Department of Health and Family Services (DHFS) is required to reimburse nursing homes for care provided to medical assistance (MA) recipients according to a prospective payment system that is updated annually. The Department's payment methodology must reflect a prudent buyer approach under which a reasonable price, recognizing select factors that influence costs, is paid for services. DHFS must establish payment standards, using recent cost reports submitted by nursing homes, which reflect projected costs to be incurred by economically and efficiently operated facilities. In federal law, this requirement is referred to as the "EEO requirement" or "Boren Amendment."

GOVERNOR

Modify the MA reimbursement formula for nursing home providers as follows:

Direct Care Target. Reduce the required statutory standard for payments under the formula's direct care cost center to 100% of the median direct care costs of all facilities in the state, rather than the standard of 110% that is used under current law. Although the statutory minimum would be reduced to 100% of the median, the Governor recommends that DHFS establish the direct care cost center at 102% of the median for provider payments in 1997-98.

Other Cost Center Targets. Reduce the formula targets for the various cost centers, as follows: (a) for support services to 102% of the statewide median from the current level of

103%; (b) for administrative and general costs to 102% of the statewide median from 103%; and (c) for fuel and utilities to 102% of the statewide median from the current level of 115%.

Nursing Home Property Costs. Reduce the percentage of capital costs in excess of the target that are reimbursed to 20%, from the current level of 40%. Nursing homes with property costs (mortgage, lease and depreciation costs) in excess of the target would have less of their property costs counted in determining the nursing home's MA payment, resulting in a lower payment.

Classification of Medicare Days. Classify all medicare-funded nursing home days as intensive skilled nursing (ISN) days, rather than classifying only 12.5% of medicare-funded days as ISN days. This change to the classification of medicare-funded days would reduce the costs that are allocated to MA patients at a nursing home, which, in turn, would reduce the nursing home's MA reimbursement rate.

Direct Care Increment Payment. Increase the direct care increment from 93% to 150% of the median for facilities in the state. The direct care increment is a fixed amount equal to the estimated inflation rate times a percentage of the direct care costs of the median cost facility (as proposed, 150% of the median cost). This adjusts the direct care reimbursement rate to reflect the rate of inflation between the common period and the reimbursement period. Since nursing homes have fiscal years ending at different times, the reported costs of each nursing home must be adjusted to a common period.

Support Services Increment. Increase the direct care increment from 93% to 100% of the median for facilities in the state. This increment serves the same purpose as the direct care increment, but is applied to the support services cost center.

High MA Utilization Adjustment. Increase the additional payment for support services to nursing homes with a high percentage of MA residents by increasing the base add-on to a facility's per diem rate from $0.25 to $0.50 per patient day.

Rate on Rate for 1998-99. For 1998-99, per diem reimbursement rates would be determined by applying a uniform percentage increase (approximately 3.5%) to the prior year's per diem rate, subject to several adjustments as determined by DHFS. This would substitute for the cost basis approach for 1998-99 only, and in the following year, 1999-00, the cost basis approach would be used again.

DISCUSSION POINTS

Direct Care Target

1. Under current law, the direct care target must be set at 110% of the statewide median cost for direct care, except that if there is insufficient funding, the target can be set lower. The Governor recommends reducing the statutory requirement from 110% to 100% of the statewide median, and recommends that for 1997-98 the direct care target be set at 102% of the statewide median.

2. DHFS estimates that setting the direct care target at 102%, rather than 110%, will reduce nursing home payments by $24.1 million annually. Nursing homes that have above average direct care costs will be adversely affected by this provision. The types of homes that have higher direct care costs are county-owned nursing homes and non-profit nursing homes. The county-owned nursing homes that are adversely affected by this provision may, to some degree, receive higher county supplemental payments as a result of lower MA per diem rates. County supplemental payments are based on the relative size of a county's operating loss.

3. The rationale for the current law provision which establishes a much higher target for direct care than the targets for other cost centers is that direct care is the most critical cost center is terms of providing adequate care to nursing home residents. A higher target will result in a larger percentage of nursing homes that will receive a sufficient reimbursement rate to cover their direct care staffing costs.

4. In support of the proposed lower target for direct care, it can be argued that a target set at 100% or above of the statewide median should be a high enough standard to ensure an adequate direct care staffing level. If half of the nursing homes in the state are able to provide direct care at or below the state target, then the rate provided by the state should be sufficient to meet EEO requirements. In addition, regulation of nursing homes and annual surveys will monitor and enforce MA staffing standards.

Classification of Medicare Days

5. In setting MA nursing home rates, DHFS currently does not collect information about other revenues, such as medicare and private pay, which offset nursing homes' costs. In order to estimate nursing homes' costs attributable to MA, medicare and private pay patients, DHFS currently classifies nursing home days under different levels of care, with ISN (intensive skilled nursing) as the highest level and SNF (skilled nursing facility care) as the second highest level. Currently, nursing homes are required to classify at least 12.5% of their medicare patient days as ISN, while the remainder are classified as SNF.

6. The Governor proposes that all medicare patient days be classified as ISN. This would result in a higher proportion of costs allocated to medicare patients and a lower proportion of costs allocated to MA patients.

7. The nursing home industry argues that most medicare patients would not meet the ISN standard and that it would be inaccurate to classify all patient days as ISN. A survey conducted by the nursing home industry in 1995-96 found that, on average, 12.5% of medicare patients would meet the ISN standard. This survey was used as the basis for the current policy of classifying 12.5% of medicare patient days as ISN days.

8. Medicare payments to nursing homes exceed the average ISN rate paid under MA. In 1995, the average medicare reimbursement rate was $192.44 per day, while the average MA reimbursement rate for the ISN level of care was $100.70 per day. However, the medicare rate includes services such as therapies and physician services, which are billed separately under MA. In 1995, MA nursing home residents had, on average, additional MA costs of $7.34 per day.

9. If all medicare patient days are not classified as ISN days, more costs would be allocated to MA, and more funding would be needed to meet the EEO requirement. DHFS estimates that $9.9 million more annually would be needed if current law were maintained.

Property Costs

10. Currently, nursing homes receive 40% of capital costs that exceed capital expenses allowed under the formula. Under the Governor's recommendation, this cost-sharing percentage would be reduced to 20%. DHFS estimates that this change reduces annual nursing home payments by $1.8 million.

11. Newer nursing homes and homes with significant debt, generally proprietary homes, benefit from the existing formula provision on cost-sharing.

12. Elimination of the current formula cost-sharing provision would decrease MA reimbursement for facilities' debt and interest payments and increase funding available for resident care. Alternatively, it could be argued that reduced capital cost-sharing would lead, over time, to fewer facility improvements and outdated facilities which could result in lower quality of care for residents and increased violations related to the health and safety of facilities.

Direct Care and Support Services Increments

13. The direct care and support services increments serve to adjust the reimbursement rate based on costs from an earlier period to reflect the effects of inflation between the earlier period and the reimbursement period. In 1995-96, the inflation adjustment for direct care costs and support services was equal to 93% of the product of the anticipated inflation rate times the median direct care costs. The Governor proposes to increase these adjustments to 150% of the

median for direct care costs and 100% of the median for support services. The increase for the direct care increment is estimated to increase annual nursing home payments by $10.1 million while the increase in the support services maximum is anticipated to increase payments by $0.6 million annually.

14. Increasing the direct care and support services increments help to ensure that the state's target for meeting the EEO requirement will be met. The combination of reducing the targets for the direct care and other cost centers while increasing the direct care and support services increments is a less expensive way to meet the state's test for the EEO requirement.

High Medicaid Utilization Adjustment

15. The Governor proposes increasing the high MA utilization payment from $0.25 to $0.50 per day for facilities with a MA occupancy of at least 70%. The estimated cost of this provision is $1.5 million annually. County-owned facilities are not eligible for this payment.

16. The increase in the high MA utilization adjustment would assist facilities that devote a larger than average proportion of their facility to the care of MA recipients and would help to compensate for the smaller proportion of private pay and other types of residents upon which to shift costs that are not allowed under the MA nursing home reimbursement formula. In addition, since the cost center targets would be reduced to levels closer to the minimum required under the EEO requirement, this change would help to insure that this requirement is met.

17. A summary of the fiscal effects of the various formula changes are identified in Table 1. Again, the aggregate funding/rate increases recommended by the Governor are the amounts/rates after the effect of these formula changes. The actual effect of these formula changes may vary from the amounts shown in the Table 1, since these estimates are based on cost reports from a year prior to the actual year of implementation. Also, these formula changes are interdependent and would change if a different combination of formula modifications were enacted. In combination, these formula changes would meet the state's current test for meeting the EEO requirement. Any further medications that would only reduce payments may result in a set of payments that would not meet that test.

TABLE 1

Estimated Annual Impact of Nursing Home Formula Changes

	Fiscal Impact All Funds (In Millions)
Direct Care Maximum at 102% of the Median	-$24.1
Support Services, Administration & General, Fuel & Utilities at 102% of the Median	-3.1
Classify All Medicare Days as ISN Days	-9.9
Reduce Cost Sharing for Property Costs to 20%	-1.8
Increase Direct Care Increment to 150% of the Median	10.1
Increase Support Services Increment to 100% of the Median	0.6
Adjust Payment to Reflect High MA Utilization	1.5
Total	-$26.7

Rate on Rate for 1998-99

18. For 1998-99, the MA nursing home reimbursement rate would be determined by applying a uniform percentage increase (approximately 3.5%) to the prior year's per diem rate, subject to several adjustments as determined by DHFS.

19. A rate-on-rate increase was used for establishing the 1996-97 rates. However, facilities that are undergoing renovations or remodeling are not able to recapture any of these additional capital costs in the year of the rate-on-rate increase. Also, even when the reimbursement rate is again based on costs, the additional capital costs associated with the year of the rate-on-rate increase are never recovered.

20. To address this problem in 1995-96, DHFS allowed nursing homes who were significantly affected by this provision to make appeals to recover a portion of these unrecovered costs.

21. One option that would not have a significant net impact on MA nursing home expenditures would be to apply the rate-on-rate method only to operational costs, and retain the cost basis for capital costs. This would allow payments to reflect recent renovations while net MA costs would not increase, since for many nursing homes, the capital cost component declines due to repayment of loans and assets having been fully depreciated. This would redistribute capital cost payments from homes without any new capital projects to homes with new capital costs.

22. The cost to the state of deleting or modifying any of the recommended formula changes can be neutral (redistribute payment only) or could have a net cost or savings to the state. Although modifications to the recommended formula changes could be made without any net funding changes, in general, modifications to the recommended formula changes may require additional funds in order to meet the EEO requirement. For example, if the direct care target is increased above 102% of the median, as recommended in SB 77, and additional funding is not added, then payments for other cost centers would have to be reduced, which may result in insufficient funding for DHFS to reimburse the costs of those centers for at least 50% of the homes in the state.

ALTERNATIVES TO BILL

1. Adopt the Governor's recommended formula changes.

2a. Modify the Governor's recommendation by deleting or modifying one or more of the recommended nursing home formula changes but do not provide any additional funding for total aggregate payments to nursing homes. The change in payments shown in the table below from maintaining current law would have to be offset by other formula changes, as determined by DHFS.

	Fiscal Impact All Funds (In Millions)
Maintain Care Maximum at 110% of the Median	$24.1
Maintain Support Services, Administration & General at 103% of Medium and Fuel & Utilities at 115% of the Median	3.1
Classify 12.5% of Medicare Days as ISN Days	9.9
Maintain Cost Sharing for Property Costs at 40%	1.8
Maintain Direct Care Increment at 93% of the Median	-10.1
Maintain Support Services Increment at 93% of the Median	-0.6
Maintain High MA Utilization Payment at 25¢ per day	-1.5
Total	-$26.7

2b. Modify the Governor's recommendation by deleting or modifying one or more of the recommended changes. In addition, adjust aggregate funding to reflect the formula modifications so that offsetting change do not have to be implemented. The fiscal change to the bill of maintaining current law is as follows:

	Fiscal Change to Bill			
	1997-98		1998-99	
	GPR	FED	GPR	FED
Maintain Direct Care Maximum at 110% of Median	$9,910,000	$14,190,000	$10,321,000	$14,623,000
Retain Support Services, Admin. & General, at 103% and Fuel & Utilities at 115% of the Median	1,275,000	1,825,000	1,328,000	1,881,000
Classify 12.5% of Medicare Days as ISN Days	4,071,000	5,829,000	4,240,000	6,007,000
Maintain Cost Sharing for Property Costs at 40%	740,000	1,060,000	771,000	1,092,000
Maintain Direct Care Increment at 93% of the Median	-4,153,000	-5,947,000	-4,325,000	-6,128,000
Maintain Support Services Increment at 93% of the Median	-247,000	-353,000	-257,000	-364,000
Maintain High MA Utilization Payment at 25¢ per day	-617,000	-883,000	-642,000	-910,000

3. Modify the Governor's recommendation for using a rate-on-rate increase for 1998-99 by excluding the capital cost center from the rate-on-rate method and by requiring that the per diem rates for capital cost center be determined based on costs.

Prepared by: Richard Megna

MO# Alt 3

BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A
JENSEN	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A

AYE 16 NO 0 ABS 0

Representative Jensen

HEALTH AND FAMILY SERVICES

Clarification of Governor's Formula Recommendations

Motion:

Move to clarify that the nursing home formula changes recommended by the Governor would:

Rate on Rate Increase. Provide that the rate on rate increase in 1998-99 would consist of two parts: (1) a 1.75% percentage increase to the individual facility's rate; and (2) a flat amount equal to 1.75% times the average rate for all facilities in the prior year.

Direct Care Increment. The recommended increase in the direct care increment from 93% to 150% of the median be only applied to residents classified under a care level other than one of the four developmentally disabled levels.

Note:

The descriptions in Paper #424 of two of the Governor's recommended nursing home formula changes under medical assistance may not fully capture the all of the details of the recommended changes. This motion would clarify the Governor's rec
areas.

MO# 1586

BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A
JENSEN	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A

AYE 16 NO 0 ABS 0

Motion #1586

Senator Jauch

HEALTH AND FAMILY SERVICES

Direct Care and Support Service Targets for Nursing Home Reimbursement

Motion:

Move to modify the Governor's recommended MA nursing home formula changes to specify that $8,003,000 of the aggregate funding increase budgeted for 1997-98 be used to increase the direct care target to 104% and the support service target to 103% of the respective statewide medians. In addition, delete $108,400 GPR and $155,200 FED in 1997-98 and $112,800 and $159,900 FED in 1998-99 to reflect lower funding for payments to nursing homes.

Note:

SB 77 provides $50,975,000 (all funds) in 1997-98 and $81,297,500 (all funds) in 1998-99 to support increased reimbursement of nursing home services in the 1997-99 biennium. Based on a recent simulation conducted by the Department, it is estimated that the recommended funding level for 1997-98 is $8,266,500 higher than would be needed to fund the Governor's recommended formula values and comply with the federal EEO requirement.

This motion would modify the recommended formula changes to specify that $8,003,000 of the funding provided in 1997-98 for nursing home rate increases be used to increase the direct care target to 104% and the support service target to 103% of the respective statewide medians. The remaining funds ($263,500 in 1997-98) would be deleted from funding for nursing home rate increases.

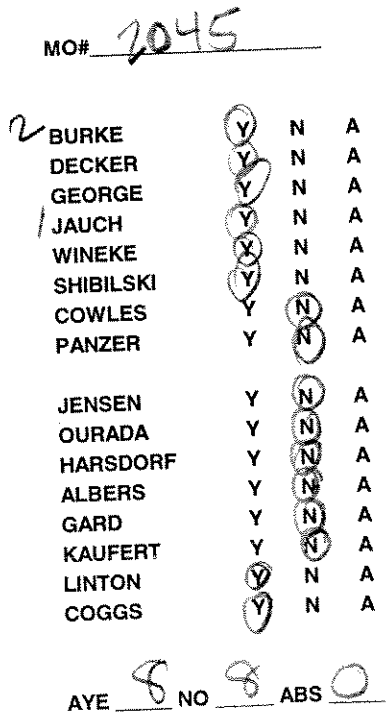
An indirect effect of this formula change is that the amount of federal matching funds that DHFS claims based on unreimbursed expenses of county-owned nursing homes may decline, since counties would tend to receive a relatively higher share of payments resulting from increases in the targets for direct care and support service costs. For each additional dollar paid to county-owned nursing homes under the per diem rates, the amount of county unreimbursed expenses or losses would decline by $1 and the state would lose approximately $1.44 in matching federal funds under the intergovernmental transfer program (IGT).

Specifying that $8,003,000 would be used to increase the direct care target would result in higher payments to counties of approximately $3.4 million, which in turn, would reduce IGT claims by up to $4.9 million. Since county-owned nursing homes would benefit to some degree

from other possible formula changes that expended the $8,003,000, the net reduction to IGT claims would be less than $4.9 million and would depend on the formula modification adopted.

It is uncertain if a reduction in IGT claims would affect the state or county-owned nursing homes. SB 77 specifies that any IGT claims above the amounts contained in the budget would be distributed to counties. Thus, if county losses are greater than projected, any loss in IGT funds would affect counties as long as the total amount of claims are within the medicare upper limit. However, if county losses are less than projected, any reduction in IGT claims would increase state GPR costs by the same amount.

[Change to Bill: -$22,200 GPR, -$315,000 FED and effect on IGT claims (See Text)]



Motion #2045

Senator Jauch

HEALTH AND FAMILY SERVICES

Direct Care and Support Service Targets for Nursing Home Reimbursement

Motion:

Move to modify the Governor's recommended MA nursing home formula changes to specify that target for the direct care be increased to 103%. In addition, provide $1,367,300 GPR and $1,832,700 FED in 1997-98 and $1,370,400 GPR and $9,40,600 FED to fund the additional payments under these formula modifications.

Note:

An indirect effect of this formula change is that the amount of federal matching funds that DHFS claims based on unreimbursed expenses of county-owned nursing homes may decline, since counties would tend to receive a relatively higher share of payments resulting from increases in the targets for direct care and support service costs. For each additional dollar paid to county-owned nursing homes under the per diem rates, the amount of county unreimbursed expenses or losses would decline by $1 and the state would lose approximately $1.44 in matching federal funds under the intergovernmental transfer program (IGT).

Specifying that $3,200,000 would be used to increase the direct care target would result in higher payments to counties of approximately $1.4 million, which in turn, would reduce IGT claims by up to $2.0 million.

It is uncertain if a reduction in IGT claims would effect the state or county-owned nursing homes. SB 77 specifies that any IGT claims above the amounts contained in the budget would be distributed to counties. Thus, if county losses are greater than projected, any loss in IGT funds would effect counties as long as the total amount of claims are within the medicare upper limit. However, if county losses are less than projected, any reduction in IGT claims would increase state GPR costs by the same amount.

[Change to Bill: $2,737,700 GPR, $3,773,300 FED and effect on IGT claims (see text)]

Motion #3002